

12475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural	
3. NAME OF DECEASED (Type or print) First Virginia Middle Hawley Last Abrahams		4. DATE OF DEATH Month Nov. Day 18 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1873
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 59	11. IF UNDER 24 HRS. Months 11 Days 19 Hours 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius S. Abrahams		14. MOTHER'S MAIDEN NAME Clara D. Vanneman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Cornelia S. Abrahams, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - 331X DUE TO Paralysis Left Side - Antonio Beltrami - Cerebral Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 10 yrs DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 20, 1959 to November 17, 1959 that I last saw the deceased alive on Nov - 17 - , 19 59 , and that death occurred at 6:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 11/19/59 ACTUAL SIGNATURE Clarence I. Benson M.D. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-21- 1959	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE X. W. Patterson, Son ADDRESS Perryville, Md		24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thoma

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1577

STATE OF TEXAS

1880

County of _____

State of _____

12475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST RI</u>				c. LENGTH OF STAY IN 1b <u>41</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X NORTH EAST</u>			
				f. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CRESS A. BEAMER</u>				4. DATE OF DEATH Month Day Year <u>11 19 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 22 1889</u>		9. AGE (In years last birthday) yrs. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>TENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PETER M BEAMER</u>				14. MOTHER'S MAIDEN NAME <u>JANE WARREN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-7071</u>		17. INFORMANT Address <u>Mrs Olive Black, Elberton RD 5 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema of sigmoid</u> DUE TO (c) <u>2</u>							INTERVAL BETWEEN ONSET AND DEATH <u>28 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1 1959</u> to <u>Nov 19 1959</u> , that I last saw the deceased alive on <u>Nov 19 1959</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Dr. G. C. Holcomb</u> M.D.				PHYSICIAN'S NAME (Type) <u>G. C. HOLCOMB</u> <u>CECIL CO. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-22-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAY VIEW METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>BAY VIEW, CECIL CO. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6-10-05

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1905

DATE OF DEATH

PLACE

NAME OF DECEASED

AGE

SEX

EDUCATION

RELIGION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>237 West Main</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harriet R. Bernard</u>				4. DATE OF DEATH Month Day Year <u>11 3 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>July 4, 1877</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>6</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>John P. Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Edward T. Williams</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the base of skull neck of the left femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>900.0</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairway</u>					
20c. TIME OF INJURY Month, Day, Year <u>2-30 11-3 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Elkton</u>		(County) <u>Cecil</u>		(State) <u>Maryland</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		DATE SIGNED <u>11-3-1959</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio Methodist</u>			
22d. LOCATION (City, town, or county) <u>Principio, Cecil Co., Maryland</u>		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				ADDRESS <u>North East, Maryland</u>			
24a. REC'D BY REGISTRAR <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown Elkhon</u>				c. LENGTH OF STAY IN 1b <u>7 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>E.</u> Last <u>Beldin</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Beldin</u>			
14. MOTHER'S MAIDEN NAME <u>Josephine Walker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>			
16. SOCIAL SECURITY NO. <u>217-03-3253</u>				17. INFORMANT <u>Elvira A. Beldin wife</u> Address <u>as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Parkinson's Disease, severe</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 18</u> , 1959, to <u>Nov. 25</u> , 1959, that I last saw the deceased alive on <u>Nov. 25</u> , 1959, and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u>				ADDRESS (Street, city or town, state) <u>123 Singers Ave., Elkhon, Md.</u>			
DATE SIGNED <u>Nov 25 1959</u>				PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>11-28-1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>CHARLESTOWN METHODIST</u>				22d. LOCATION (City, town, or county) (State) <u>CHARLESTOWN, CEIL, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Prant</u>				ADDRESS <u>North East Md</u>			
24a. REC'D BY REGISTRAR <u>NOV 30 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>			

(1)

(2)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12477

CERTIFICATE OF DEATH

12455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANK Last BIGGS		4. DATE OF DEATH Month November Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1875
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Biggs		14. MOTHER'S MAIDEN NAME Susan Hessey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Raymond Biggs,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with extension to liver 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 0 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 59 , to Nov 22 , 19 59 , that I last saw the deceased alive on Nov 22 , 19 59 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 22 NOV 59	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		Cecilton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 25, 1959	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Mullington Md.	
24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kram	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wyoming, D.I.</u> d. STREET ADDRESS <u>Wyoming Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <u>Isaac</u> First <u>Joshua</u> Middle <u>Bishop</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1959</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-36</u>		9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Magnolia, Del</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>Walter F. Bishop</u>								14. MOTHER'S MAIDEN NAME <u>Rachel Shahan</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Navy</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs. Rachel Bishop, Wyoming, Del. R.D.1</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: <u>Crushed both sides of chest</u> IMMEDIATE CAUSE (a) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 30%;"> DUE TO (b) DUE TO (c) </div> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car hit electric light pole</u>																							
20c. TIME OF INJURY Month, Day, Year <u>2:10</u> a. m. <u>11/14</u> <u>59</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 282</u>				20f. (City or town) <u>Cecilton, Cecil,</u> (County) <u>Md.</u> (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																											
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-14-59</u>																			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>												22b. DATE THEREOF <u>17/NOV/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Lake side</u>				22d. LOCATION (City, town, or county) <u>over Del</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Terbat</u> ADDRESS <u>1111 N. Frederick St.</u>																24a. REC'D BY REGISTRAR <u>Nov 17 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 11. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12457

12478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland c. LENGTH OF STAY IN lb 2M 14D d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 132 Fairmont Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last August C BUCKHOLZ		4. DATE OF DEATH Month Day Year November 17, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-88
9. AGE (in years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Jersey City, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Buckholz		14. MOTHER'S MAIDEN NAME Frieda Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO None	
17. INFORMANT VAH., Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, lower lobes 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized, severe		INTERVAL BETWEEN ONSET AND DEATH 3-4 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VAH., Perry Point, Md. and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. Garey		ADDRESS (Street, city or town, state) VAH., Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, removed		22b. DATE THEREOF 11/23/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft Myers, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Havre DeGrace, Md.		24a. REC'D BY REGISTRAR NOV 27 59	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

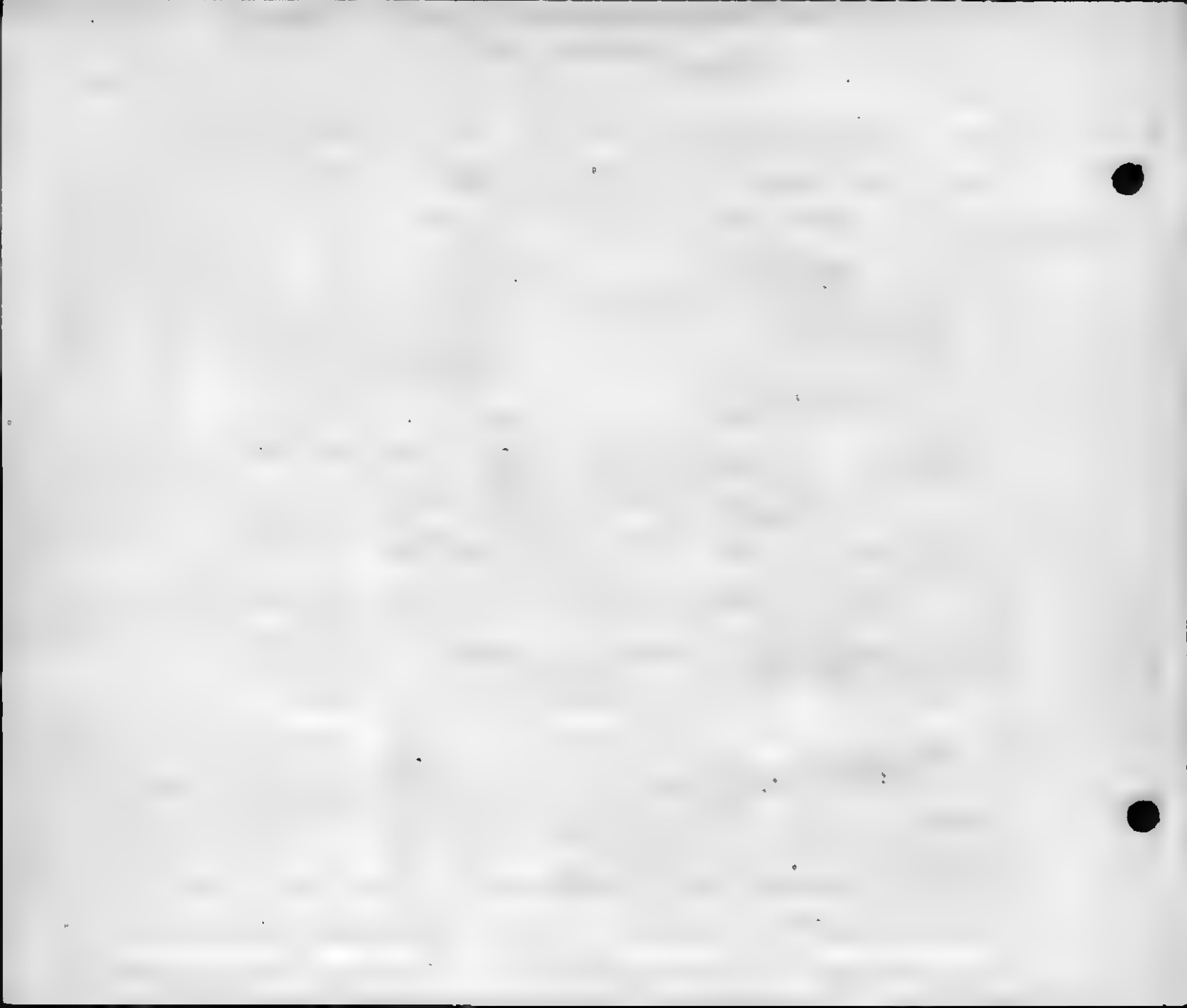
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil - MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Bridge Street.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton - Md	
4. DATE OF DEATH Nov. 13 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Murray Wilkerson Bounce		4. DATE OF DEATH Nov. 13 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25-1882 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaborne		10b. KIND OF BUSINESS OR INDUSTRY Hotel Co.	
11. BIRTHPLACE (State or foreign country) Baltimore - Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Davis Bounce		14. MOTHER'S MAIDEN NAME Mary Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-2069	
17. INFORMANT wife Bessie Draper Bounce		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) General Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 mo unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1959 to Nov 13 1959, that I last saw the deceased alive on Nov 12 1959, and that death occurred at 12:00 P.M. from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE V. H. McKnight		ADDRESS (Street, city or county) 115 Bridge St - Elkton - Md	
PHYSICIAN'S NAME (Type) V. H. McKnight		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-59	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home 200 N. 2nd St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 59	24b. REGISTRAR'S SIGNATURE Arthur S. Hunt



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Reg. Dist. No.

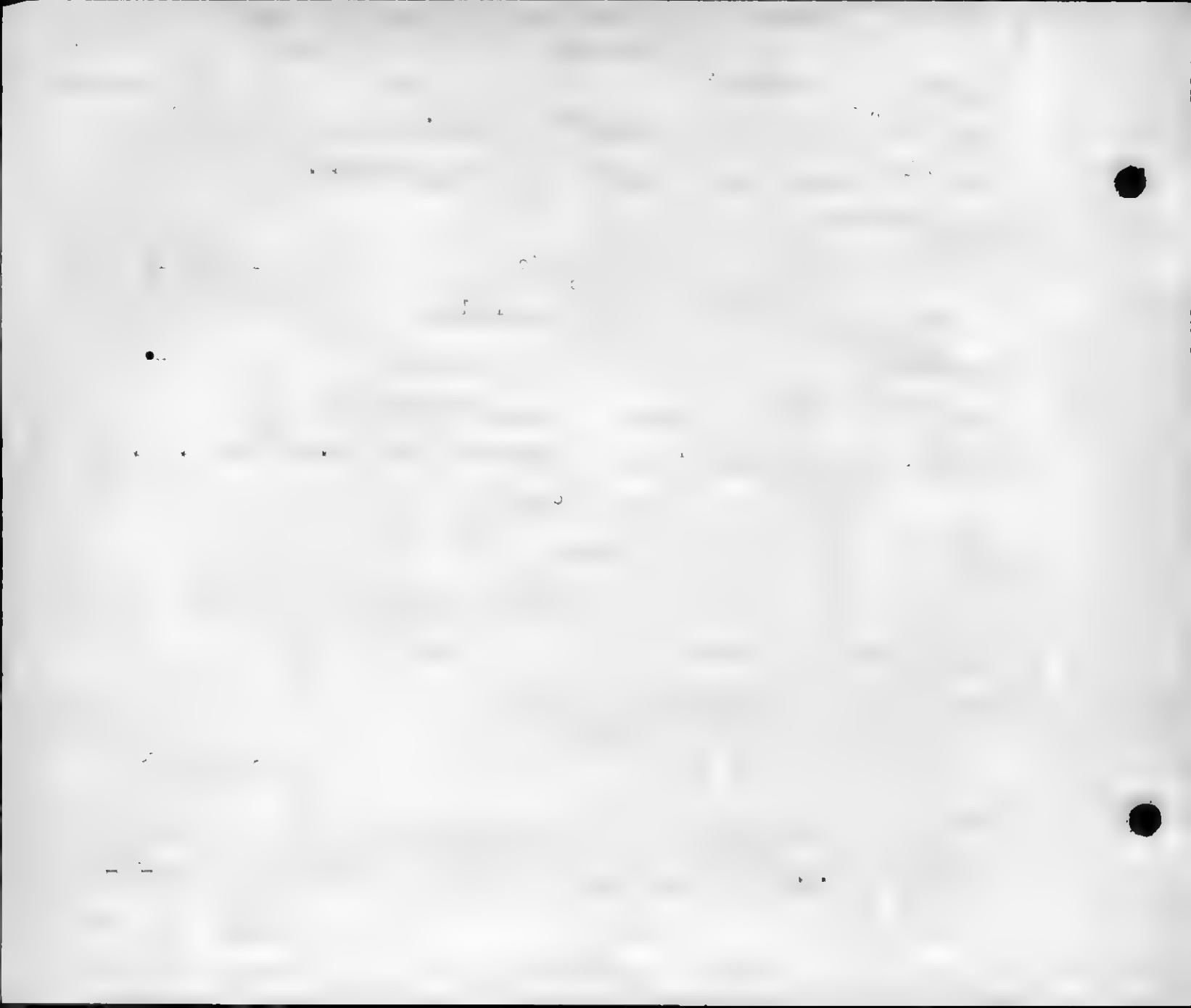
12479

item 12 Film 222 11-23-59 et

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert c. LENGTH OF STAY IN 1b 2 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Graybeal Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Chafchic Last John Chafchic			4. DATE OF DEATH Month 11 Day 17 Year 1959				
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881		9. AGE (In years last birthday) 78 yrs. 10. IF UNDER 1 YEAR Months 78 Days 17 Hours 1959 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Poland			
12. CITIZEN OF WHAT COUNTRY Poland			13. FATHER'S NAME no information				
14. MOTHER'S MAIDEN NAME no information			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				
16. SOCIAL SECURITY NO. no			17. INFORMANT Graybeal Nursing Home, Nottingham, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R.C. Dodson			DATE SIGNED 11-18-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.			
22d. LOCATION (City, town, or county) (State) Calvert Md.		23. FUNERAL DIRECTOR'S SIGNATURE Address Rising Sun Md					
24a. REC'D BY REGISTRAR DATE NOV 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. K...					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1843. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

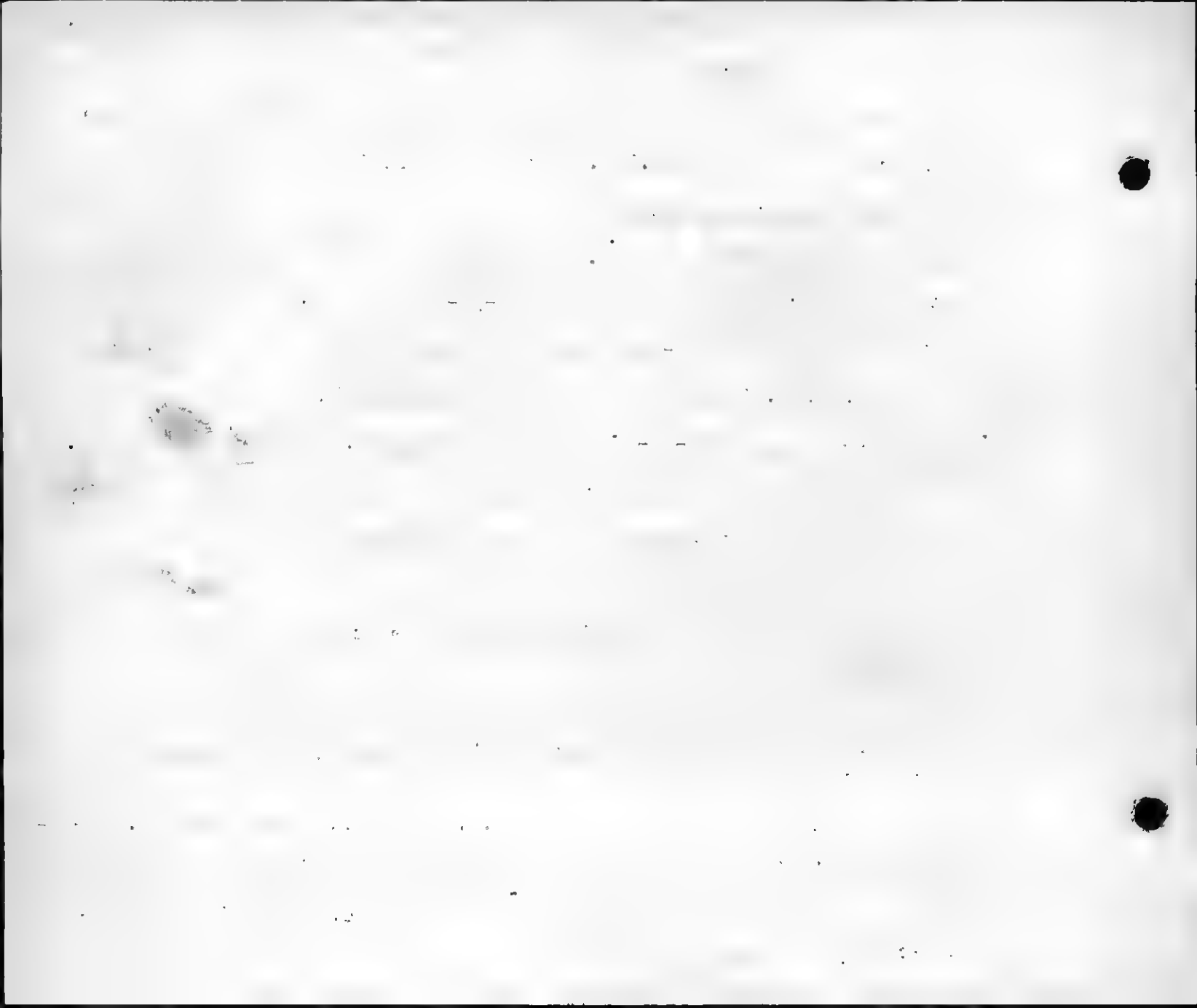
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12460

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 14yrs.1mo.1days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Queen Annes c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS 17X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle E. Last CONLEY		4. DATE OF DEATH Month November Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-94
9. AGE (in years last birthday) 65		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel P. Conley		14. MOTHER'S MAIDEN NAME Augusta Walls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 214-10-0715	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe		INTERVAL BETWEEN ONSET AND DEATH 5 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 15, 1945 , to November 16, 1959 , and that death occurred at 2:30 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 11-16-59			
ACTUAL SIGNATURE J. L. GAREY PHYSICIAN'S NAME (Type) J. L. GAREY		M.D. V.A. Hospital, Perry Point, Md. Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-59	
22c. NAME OF CEMETERY OR CREMATORY Centreville		22d. LOCATION (City, town, or county) (State) Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Barton Brothers ADDRESS Centreville, Maryland		24a. REC'D BY REGISTRAR NOV 19 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			



CERTIFICATE OF DEATH

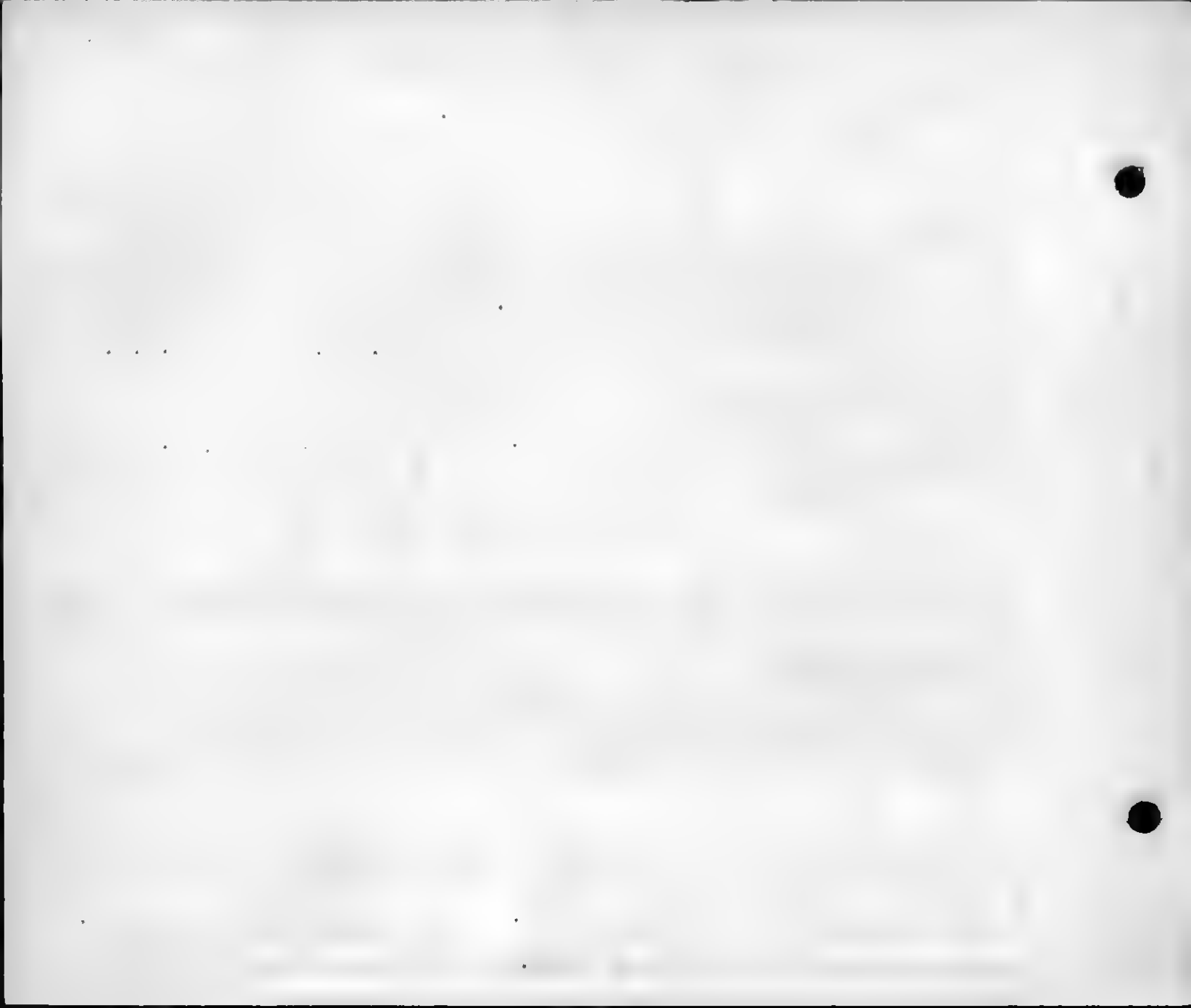
Reg. Dist. No.

12481

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>				c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Colora</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lewis</u> First <u>Alexander</u> Middle <u>Ewing</u> Last				4. DATE OF DEATH Month <u>11</u> / Day <u>16</u> / Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Machinery</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Elie Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Lenna May Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-1778</u>		17. INFORMANT Address <u>Mrs. Dorothy Ewing, Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. ft. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7</u> , 19 <u>58</u> to <u>11/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/16</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>11/17/59</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>				ADDRESS <u>Rising Sun, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

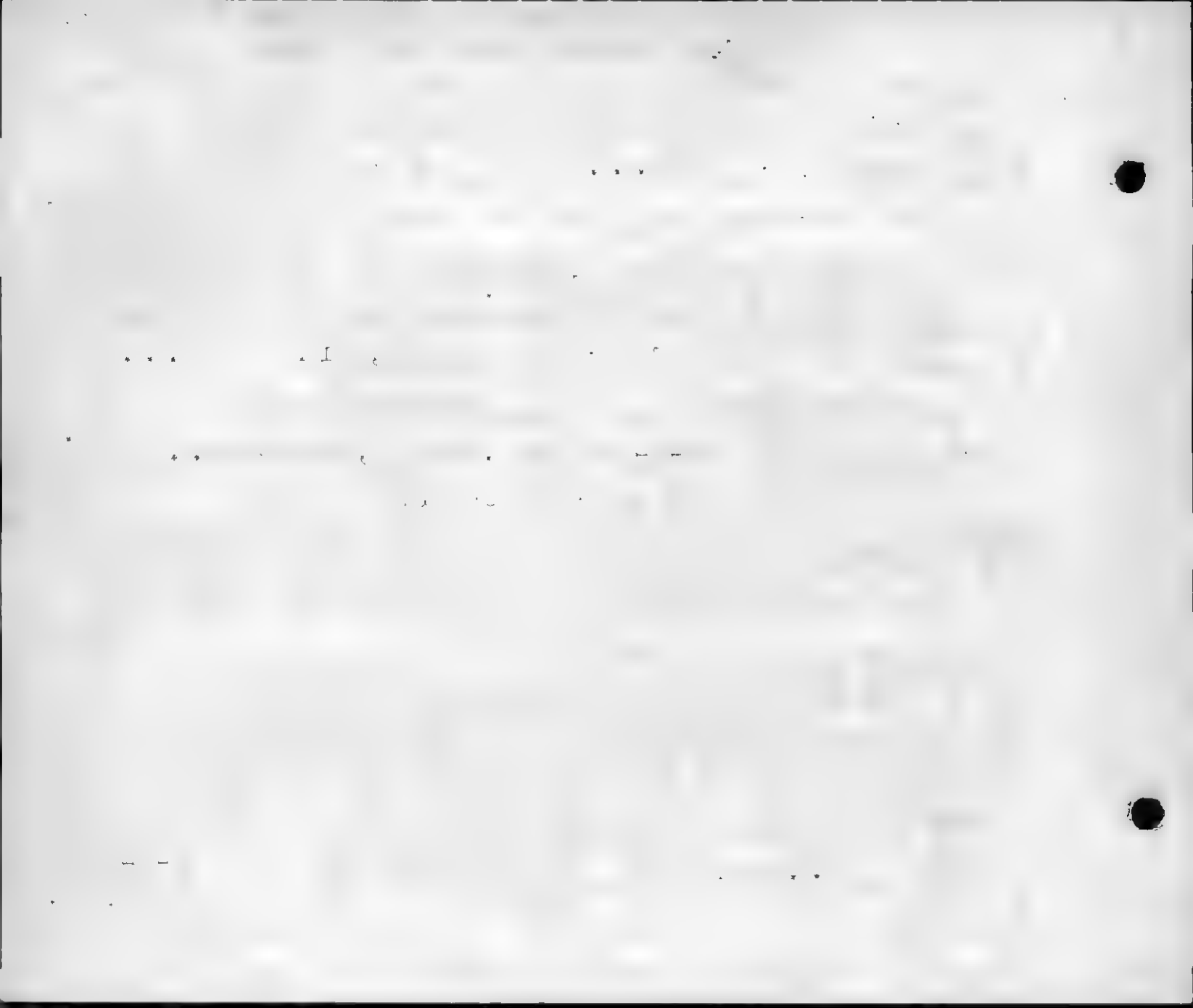
12462

12467

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willard Brown Frederick</u>				4. DATE OF DEATH Month Day Year <u>11 18 19 59</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30, 1893</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gravel Firm</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Frederick</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Walmsley</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-5299</u>		17. INFORMANT Address <u>Ann G. Frederick, 202 Medford R.D., Wilmington, Del.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4:30.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Wilmington, Newcastle Co., Del.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-18-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Newcastle Co., Del.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph R. Grant North East md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12483

12482

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna First Blanche Middle Gillespie Last				4. DATE OF DEATH Nov. Month 19 Day 19 Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 // 22 // 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Albert Boyd				14. MOTHER'S MAIDEN NAME Emma Catherine MacDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nellie Weiser		1128 S. Paxon St. Phila. 43, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 , 19 59 , to 11/19 , 19 59 , that I last saw the deceased alive on 11/19 , 19 59 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 11/20/59							
ACTUAL SIGNATURE Neal Taylor M.D. Rising Sun, Md.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/1959		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Colora Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Muller ADDRESS Rising Sun, Md.				24a. REC'D BY REGISTRAR NOV 23 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

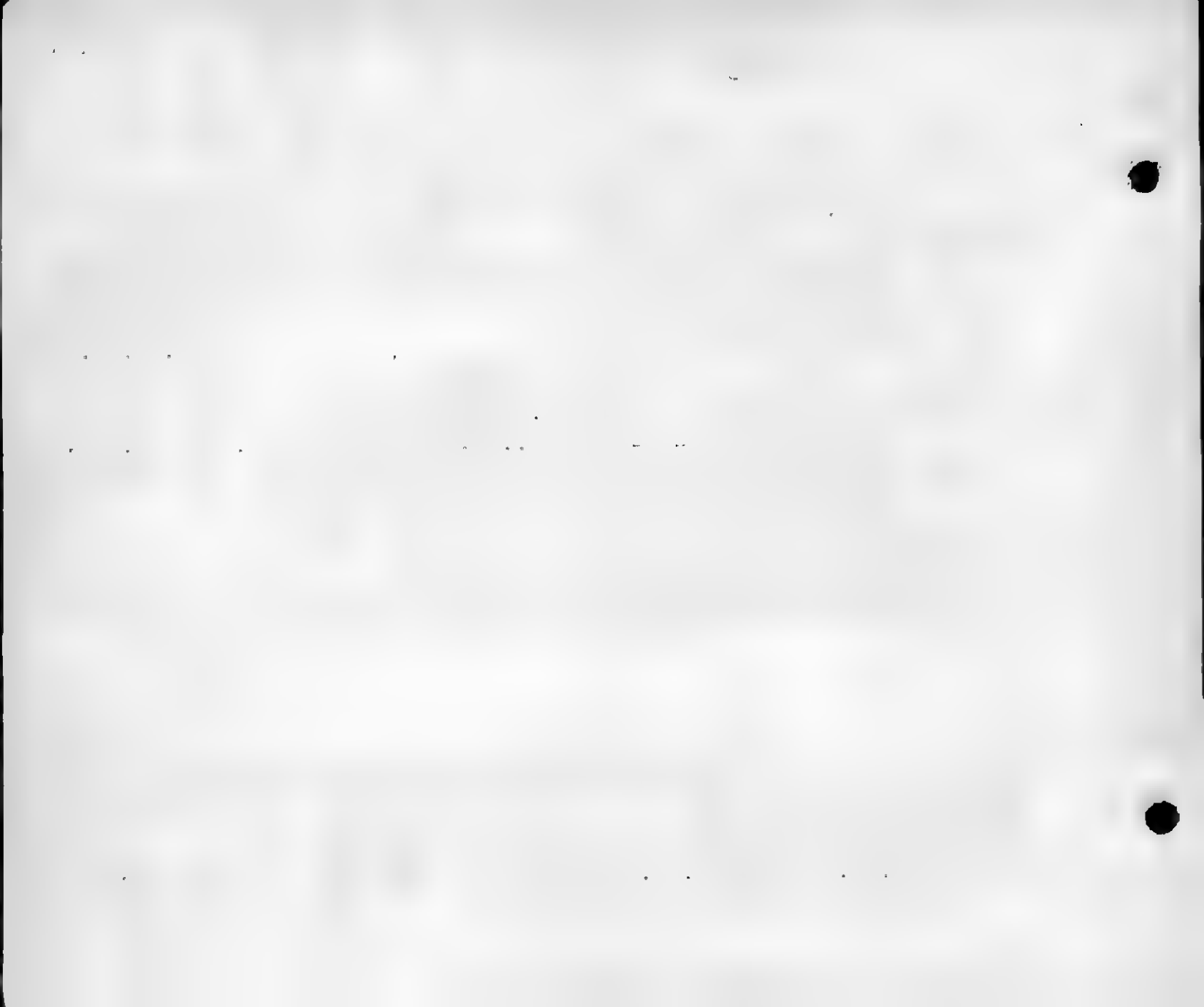
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East River Beach</u> c. LENGTH OF STAY IN 1b <u>Visiting</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Arundel Corp. property</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>249 Mackall Street 21</u> d. STREET ADDRESS <u>Elkton</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Raymond</u> Middle <u>Hague</u> Last				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Cecilton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Samuel Edward Hague</u>						14. MOTHER'S MAIDEN NAME <u>Mary Harris</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-07-1789</u>		17. INFORMANT Address <u>Mrs. S. Raymond Hague, Elkton, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accute Coronary Occusition</u> ¹ <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVA. BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) <u>R. C. Dodson, M. D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>				22d. LOCATION (City, town, or county) <u>Elkton, Maryland</u> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>						ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

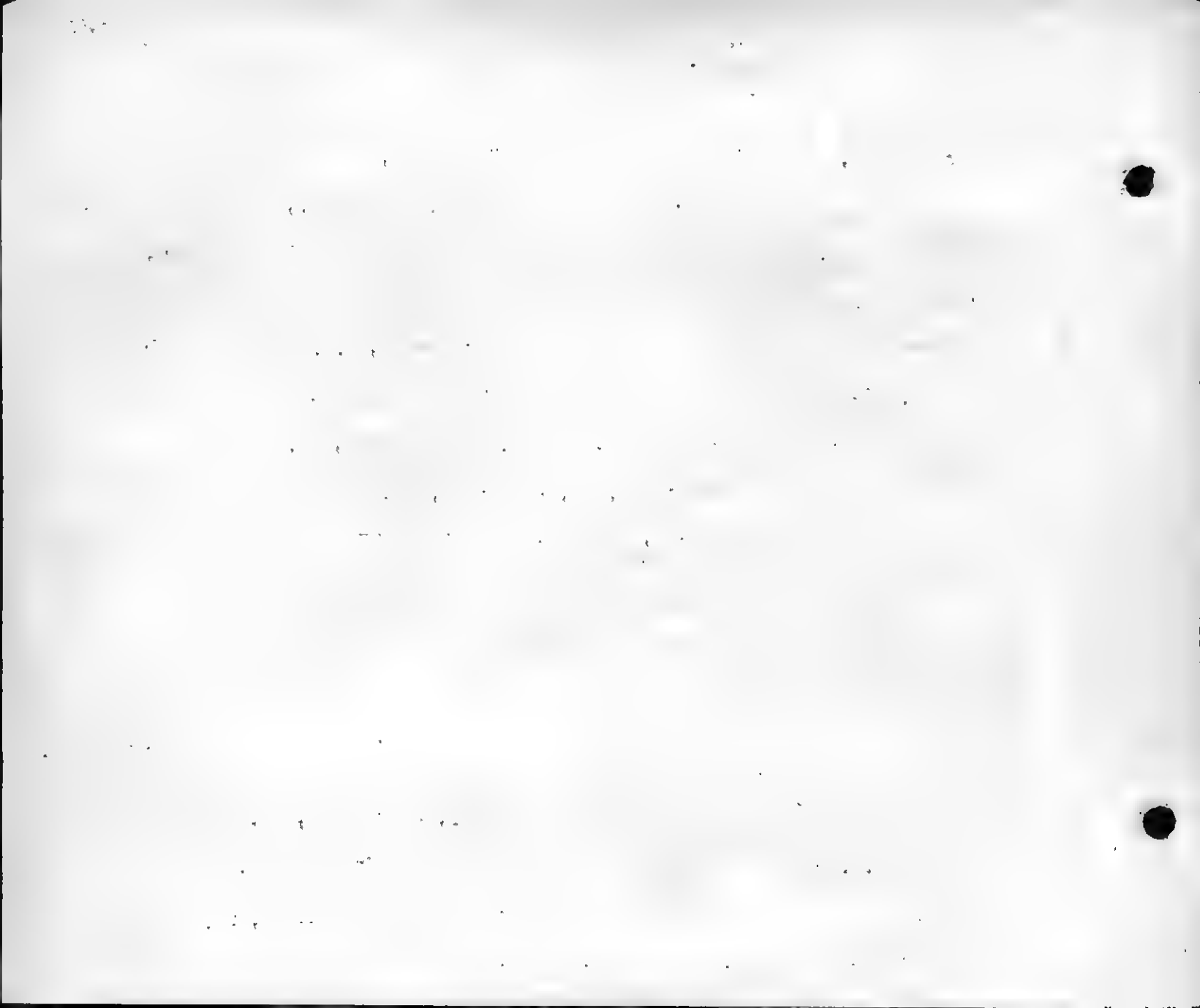
Item 4 File # 232 11-30-59 et

CERTIFICATE OF DEATH

12465

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Delaware b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veteran's Hospital		e. STREET ADDRESS 1533 W. Fourth St.,	
3. NAME OF DECEASED (Type or print) First JULIUS N Middle HEYWARD Last		4. DATE OF DEATH Month November Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/24
9. AGE (In years last birthday) 34 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charleston, S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JULIUS N. HEYWARD		14. MOTHER'S MAIDEN NAME BEATRICE SPENCER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-20-2669	
17. INFORMANT VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis, bilateral, Severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myelitis, Chronic, at level of T-7 DUE TO cause unknown (c)		INTERVAL BETWEEN ONSET AND DEATH 8-10 Wks Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16/59 , 19, to 11/17/59 , 19, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. L. Garey		M.D. VAH, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-59	
22c. NAME OF CEMETERY OR CREMATORY Balto nat cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE W KELSON		ADDRESS 1348 N. Calhoun St. Balto., Md.	
24a. REC'D BY REGISTRAR DATE NOV 19 '59		24b. REGISTRAR'S SIGNATURE William L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1246S

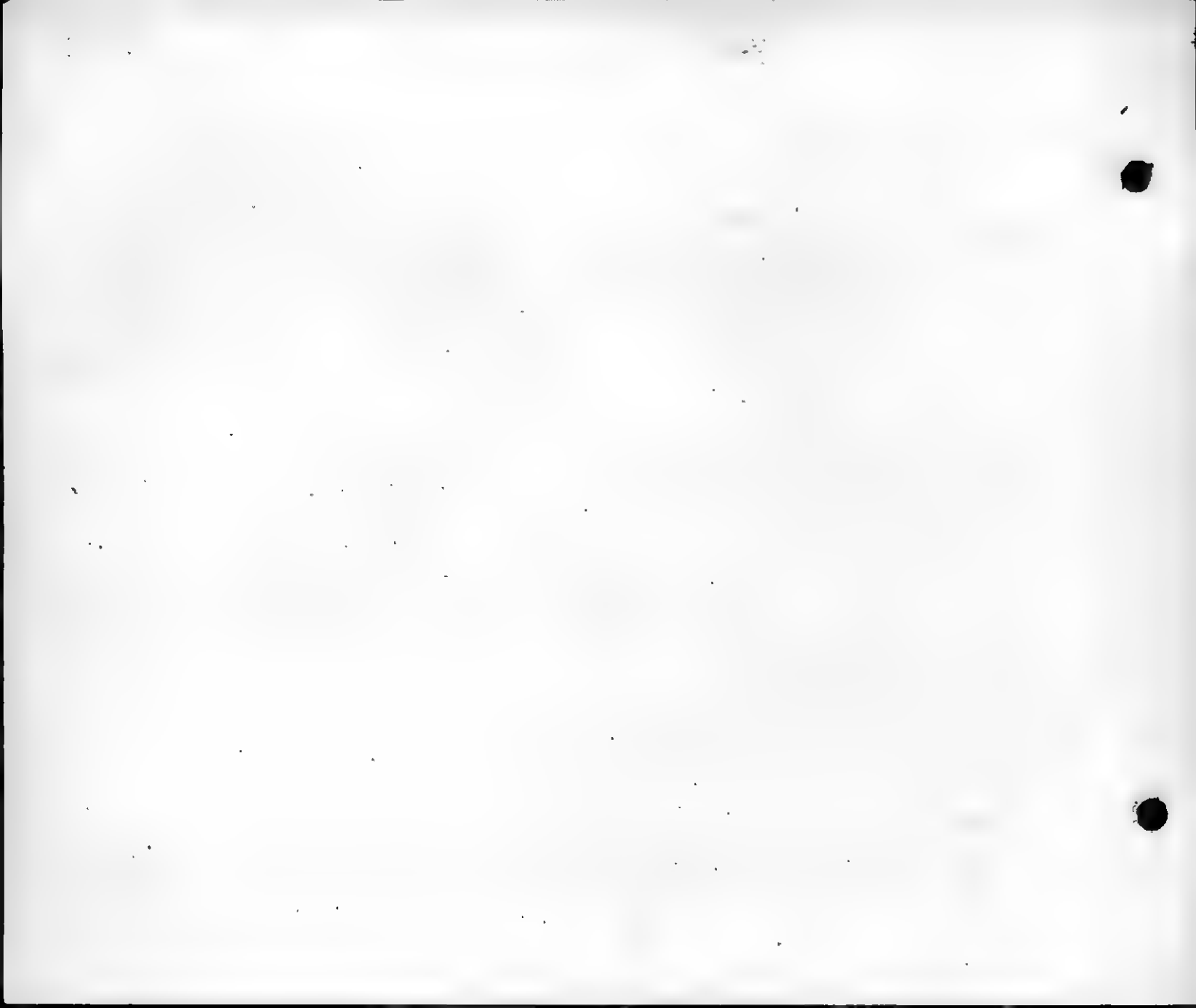
CERTIFICATE OF DEATH

12466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>156 W. Main</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herbert</u> Last <u>Jeffers</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1876</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Herbert Jeffers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Catwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-32-1316</u>		INFORMANT <u>John H. Jeffers</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE AZOTEMIA</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC STARVATION</u> DUE TO (c) <u>CEREBRAL VASCULAR SCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 weeks</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:20</u> a. m. <u>11/1</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8:20</u> 19 <u>59</u> to <u>11/1</u> 19 <u>59</u> that I last saw the deceased alive on <u>11/1</u> 19 <u>59</u> , and that death occurred at <u>3:52 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.				ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>11/2/59</u>			
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u>				<u>Elkton Md.</u>			
22a. BURIAL, CREMAT., ON-REMOVAL (Specify)		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knease</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12469

CERTIFICATE OF DEATH

Reg. Dist. No.

12467

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Bow Street.				d. STREET ADDRESS 205 Bow Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William W. Johnston				4. DATE OF DEATH Month Day Year Nov. 9 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1923	9. AGE (In years last birthday) 36 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry		11. BIRTHPLACE (State or foreign country) Circleville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Johnston				14. MOTHER'S MAIDEN NAME Catherine Phares			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-12-3627		INFORMANT Address Mrs. Emma B. Johnston, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Heart Failure 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH Oct 23-
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to Nov. 9, 1959, that I last saw the deceased alive on Nov. 8, 1959, and that death occurred at 9:25 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Oneford H. Spearman, M.D. Cecil, Md. Nov. 10-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORY Calhoun		22d. LOCATION (City, town, or county) (State) Nr. Circleville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				24a. REC'D BY REGISTRAR NOV 13 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

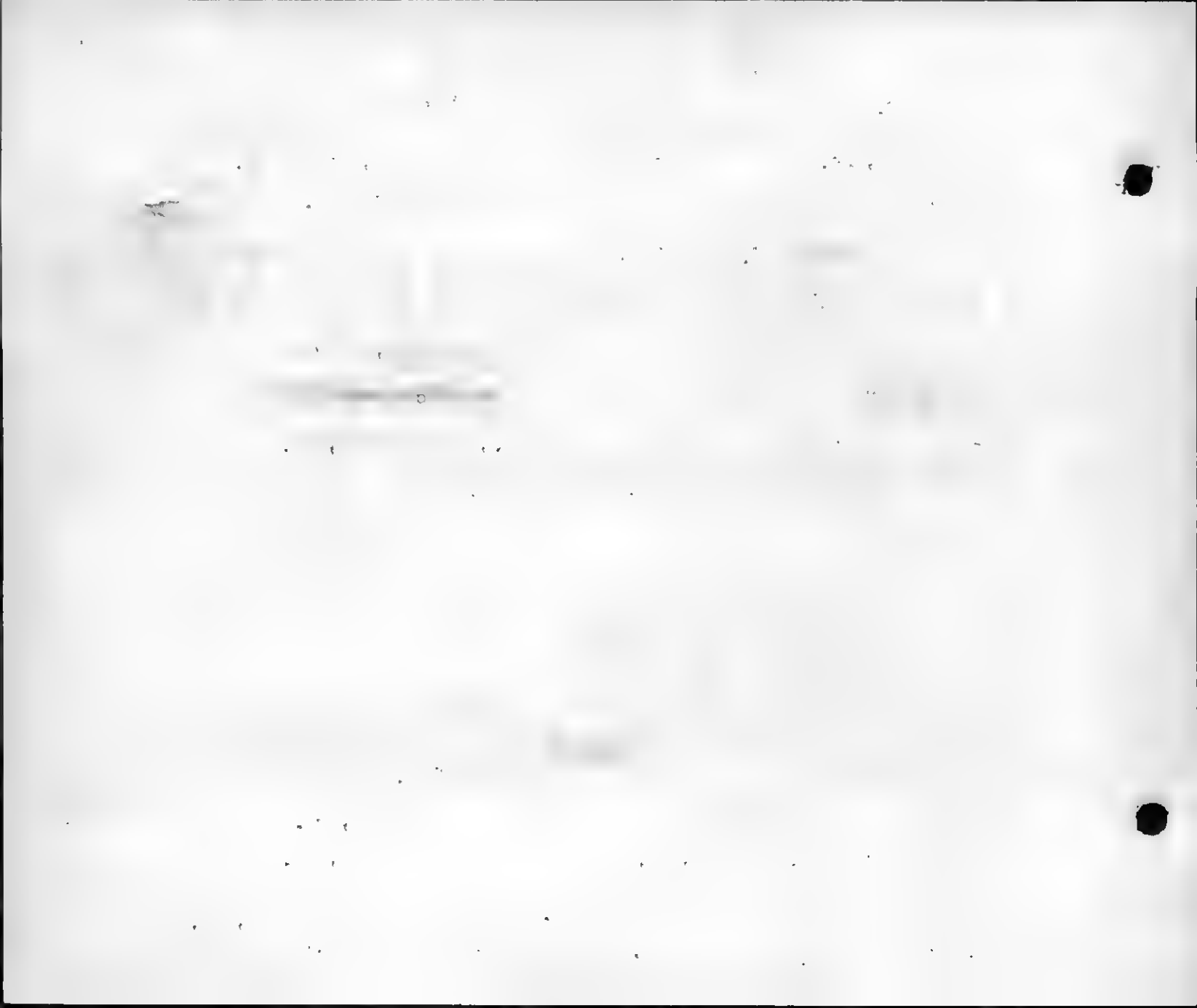
12485

CERTIFICATE OF DEATH

12468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 6Y-2M -2D	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg, Balto. Md.	
f. STREET ADDRESS 608 Old Home Road.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILBUR J. LEPPER		4. DATE OF DEATH Month November Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/09
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB LEPPER		14. MOTHER'S MAIDEN NAME Mary McDonald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema. 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH 3 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/9/53 , 19 53 , to 11/11/ , 19 59 , that I last saw the deceased alive on 11/11/ 59 , 19 59 , and that death occurred at 2 p.m. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Perry Point, Md. DATE SIGNED 11/11/59			
ACTUAL SIGNATURE Joseph M. Hooper M.D.		PHYSICIAN'S NAME (Type) JOSEPH M. HOOPER, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/16/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc.		24a. REC'D BY REGISTRAR DATE 11/11/59	
ADDRESS 6009 Harford Rd.		24b. REGISTRAR'S SIGNATURE Arthur A. Thane	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

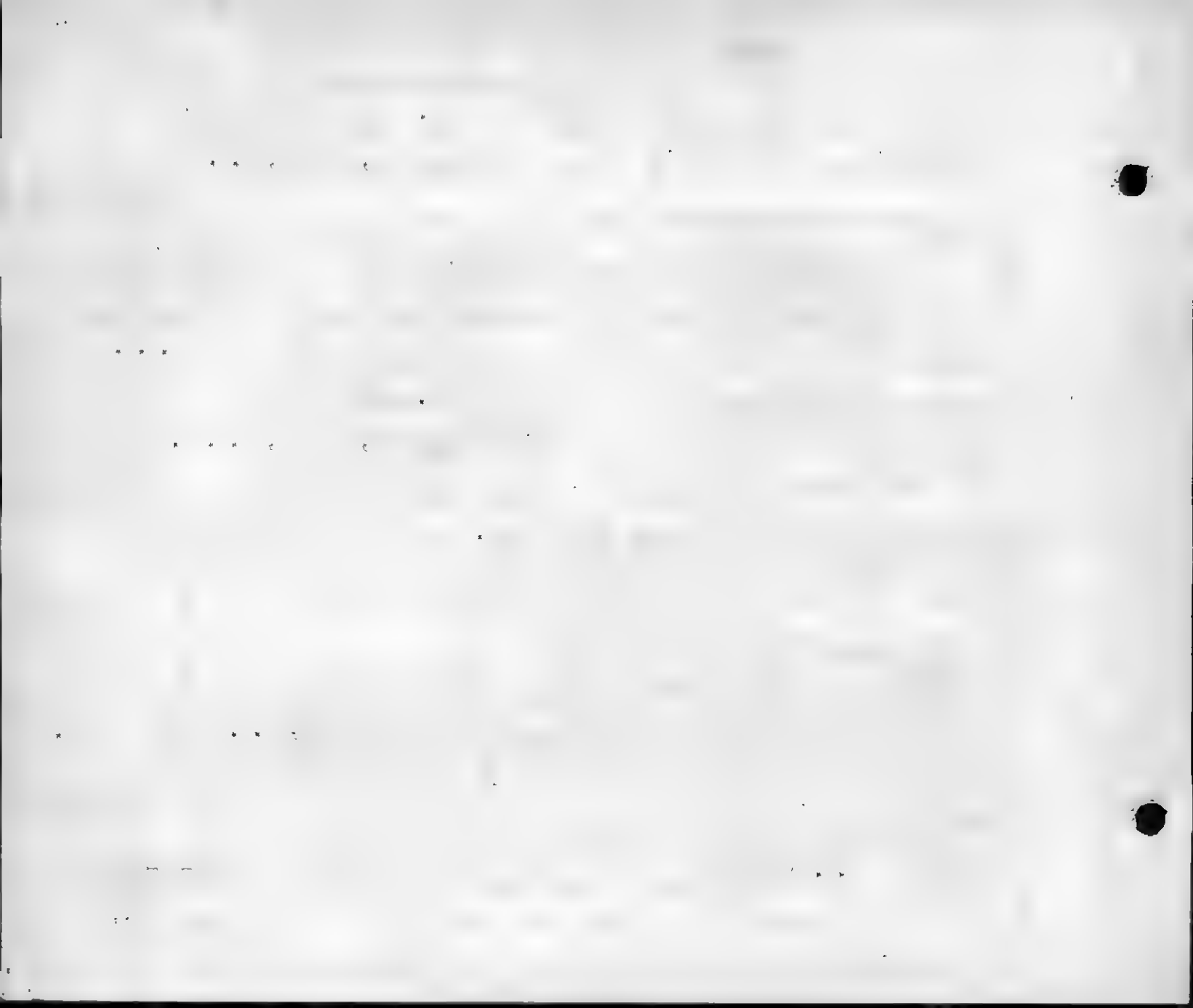
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12469

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barksdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barksdale, Elkton, R.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mary Middle I Last Mahoney		4. DATE OF DEATH Month 11 Day 21 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-1916
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mahoney		14. MOTHER'S MAIDEN NAME Mary J. Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT William Mahoney, Elkton, R.D.Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 32 Caliber pistol wound below left nipple 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) through to the back. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot herself with 32 caliber revolver	
20c. TIME OF INJURY Month, Day, Year 730 a. m. 11 21 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Elkton, R.D. Cecil Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 11-22-59	
EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-24-1959	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		24a. REC'D BY REGISTRAR NOV 24 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12470

CERTIFICATE OF DEATH

Reg. Dist. No.

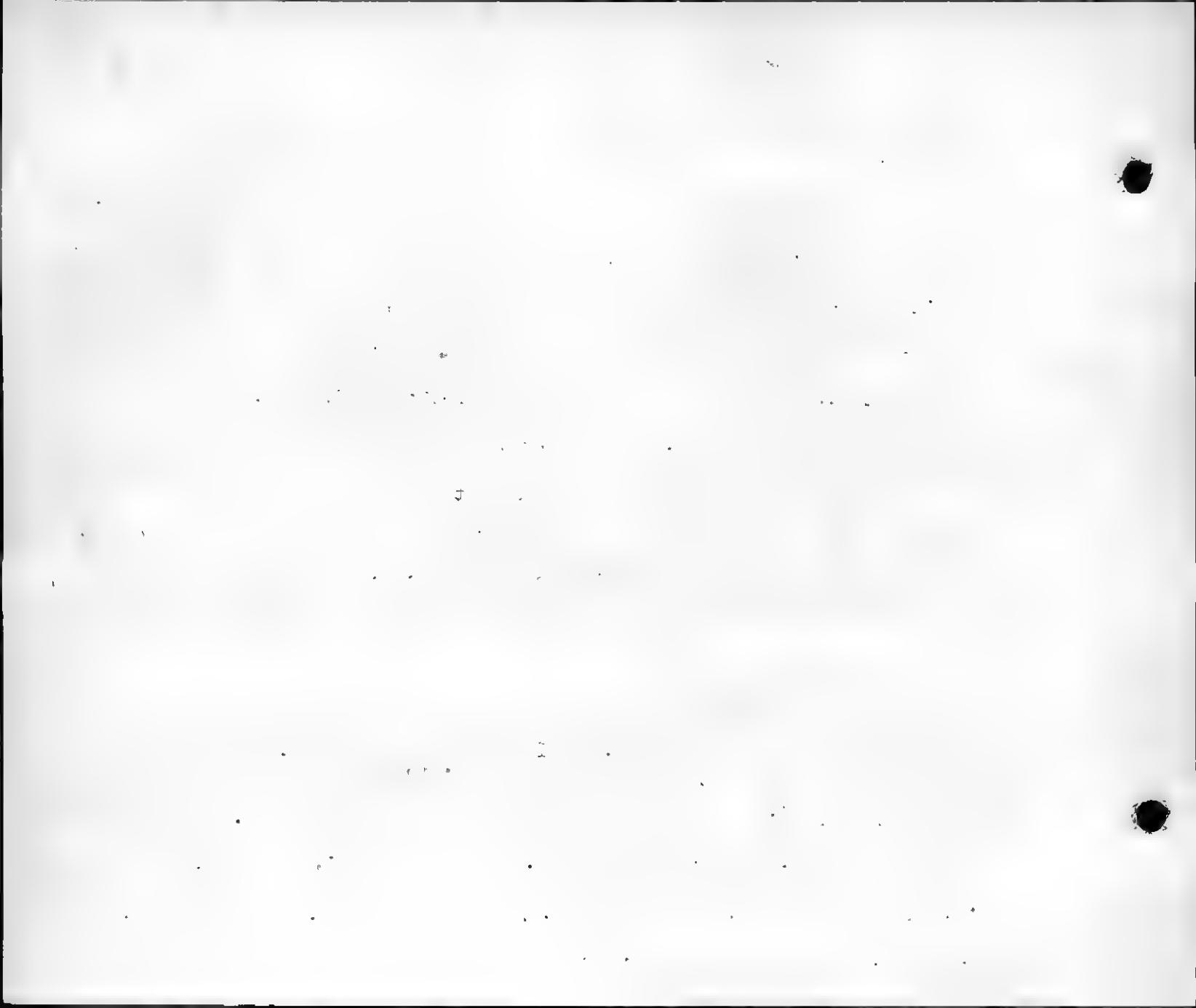
12470

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle W. Last Moore				4. DATE OF DEATH Month 11 Day 20 Year 1959			
5. SEX Female	6. COLOR OR RACE Whit	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1881		9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months 11 Days 20	IF UNDER 24 HRS. Hours 15 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. White				14. MOTHER'S MAIDEN NAME Katherine E. Birmingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		INFORMANT Barclay Moore Jr. North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 420.1 DUE TO Acute coronaru thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis of cardiovascular disease DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1959 to November 20, 1959 , that I last saw the deceased alive on November 20, 1959 , and that death occurred at 6:10 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.				ADDRESS (Street, city or town, state) 233 E. Main St. North East, Maryland DATE SIGNED 11/20/59			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-1959		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12471

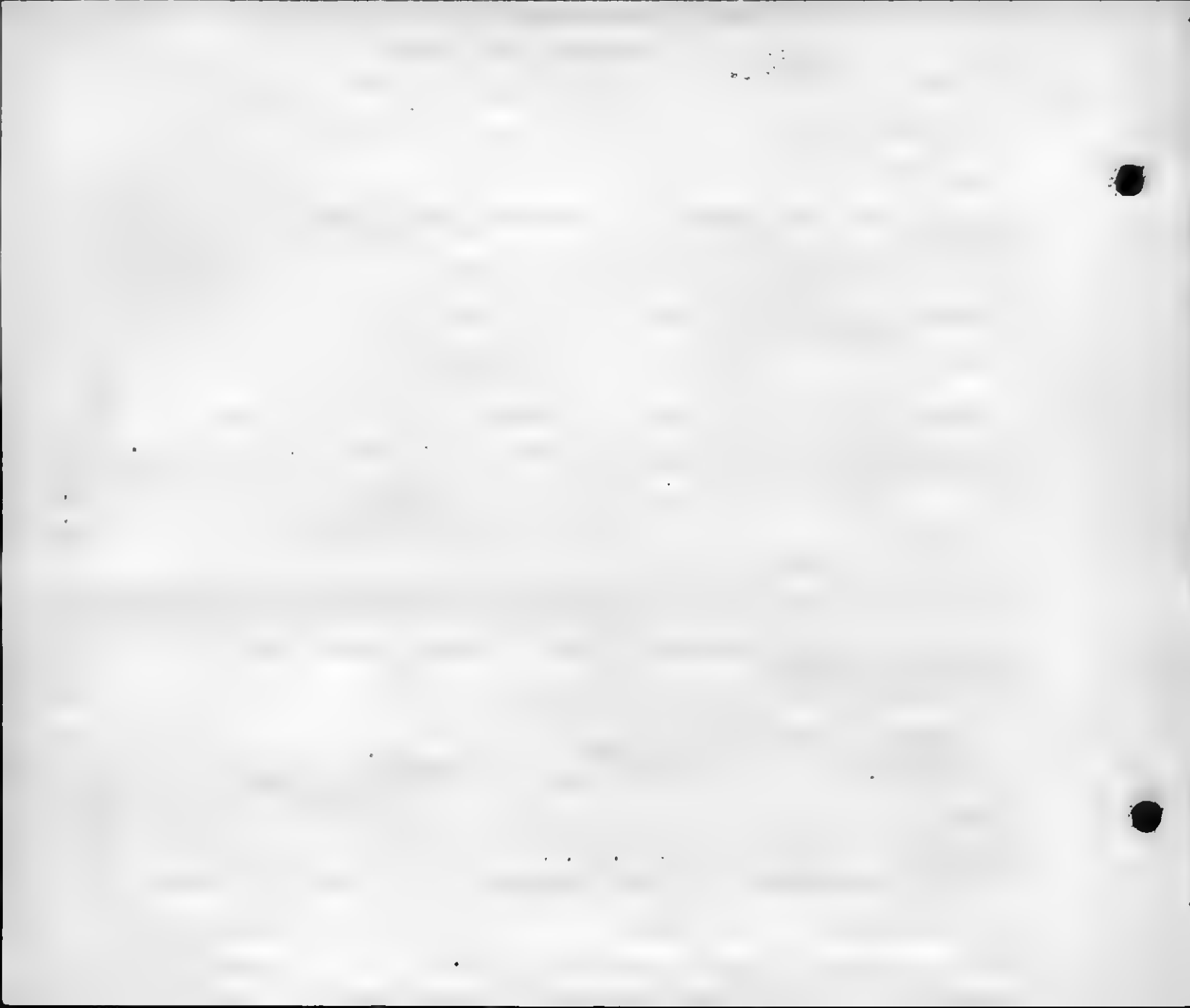
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Landing Lane		d. STREET ADDRESS 112 Landing Lane	
3. NAME OF DECEASED (Type or print) JOHN THOMAS MOORE		4. DATE OF DEATH November 7 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1904
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Moore		14. MOTHER'S MAIDEN NAME Annie Mc Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. John T. Moore		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Acute cerebrovascular accident 44-1 DUE TO Cerebrovascular accident -left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 19 57, to Nov. 7 19 59, that I last saw the deceased alive on Nov. 7 19 59, and that death occurred at 12:35a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 F. Main Street	
PHYSICIAN'S NAME (Type) C. Ralph Andrews, Jr., M.D.		DATE SIGNED 11/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Nov. 10, 1959	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 12 '59	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

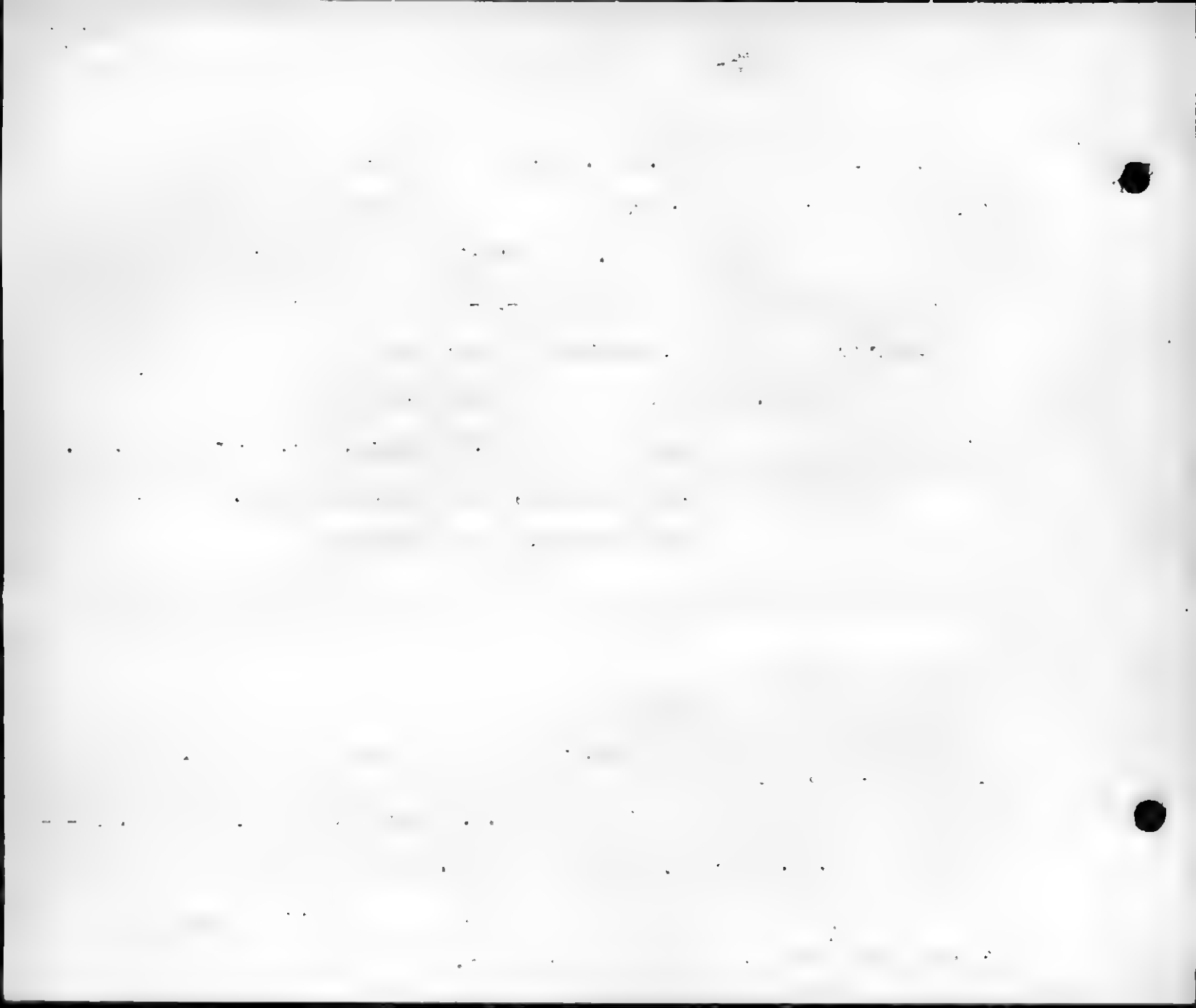
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27yrs. 10mo. 5days		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 322 Willis		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES		Middle E.		Last MUMFORD		4. DATE OF DEATH Month November		Day 1	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-94		9. AGE (In years last birthday) yrs 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William J. Mumford				14. MOTHER'S MAIDEN NAME Emily Larimore					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		INFORMANT unknown		Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VA		(County) (State)	
21. I certify that I attended the deceased from December 27, 1931 , to November 1, 1959 and that death occurred at 7:20p.m. from the causes and on the date stated above.									
ACTUAL SIGNATURE J. L. Garey		M.D.		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.				DATE SIGNED 11-3-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist							
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/5-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR NOV 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

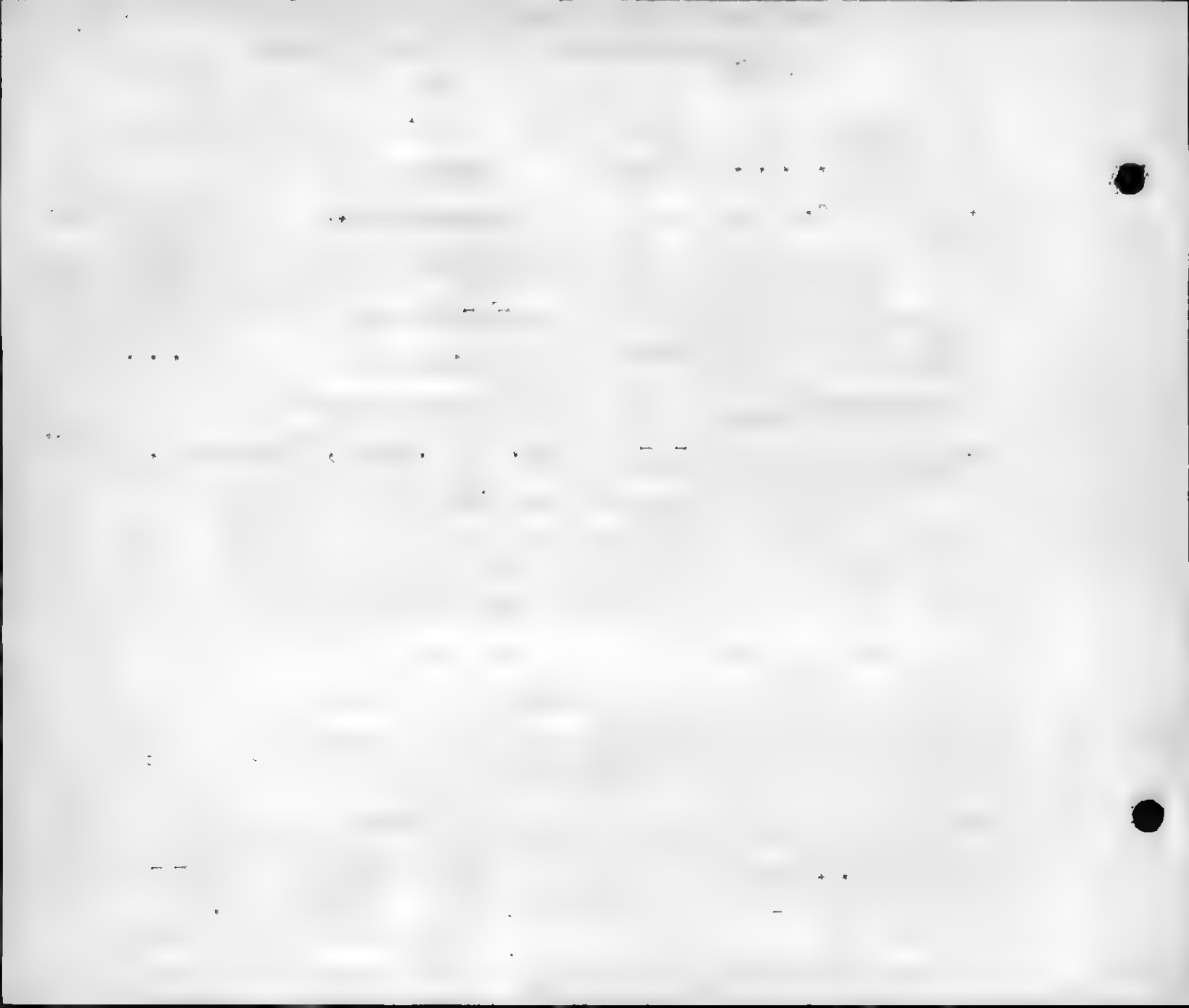
12473

12488

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Del. b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, R.F.D.		c. LENGTH OF STAY IN lb 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark		d. STREET ADDRESS 6 Prospect Ave?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Assembly Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle M Last Murphy				4. DATE DEATH 11 Month 9 Day 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1899		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY Explosive		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Murphy				14. MOTHER'S MAIDEN NAME Elizabeth McHale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 203-03-6809		17. INFORMANT Mrs. Mary C. Murphy, 6 Prospect Ave. New Ark			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or county) (State) Newark, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones				ADDRESS Newark, Del		24a. REC'D BY REGISTRAR NOV 13 59	
						24b. REGISTRAR'S SIGNATURE C. H. Jones	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12489

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

12474

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Surf City	
c. LENGTH OF STAY IN 1b 5 mo. 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Lagoon Drive, South	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle ELISE Last OSBORNE		4. DATE OF DEATH Month November Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-78
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY Reg. Nurse	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore B. Osborne		14. MOTHER'S MAIDEN NAME Lydia Underhill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 120.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized, severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH 10-12 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8 , 19 59 , to November 19 1959 , and that death occurred at 7:00 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D.V.A. Hospital, Perry Point, Md. DATE SIGNED 11-20-59 ACTUAL SIGNATURE J. L. Garey PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11/22/59	
22c. NAME OF CEMETERY OR CREMATORY Beverly National		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
24b. REGISTRAR'S SIGNATURE Clara S. Hanna			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12472

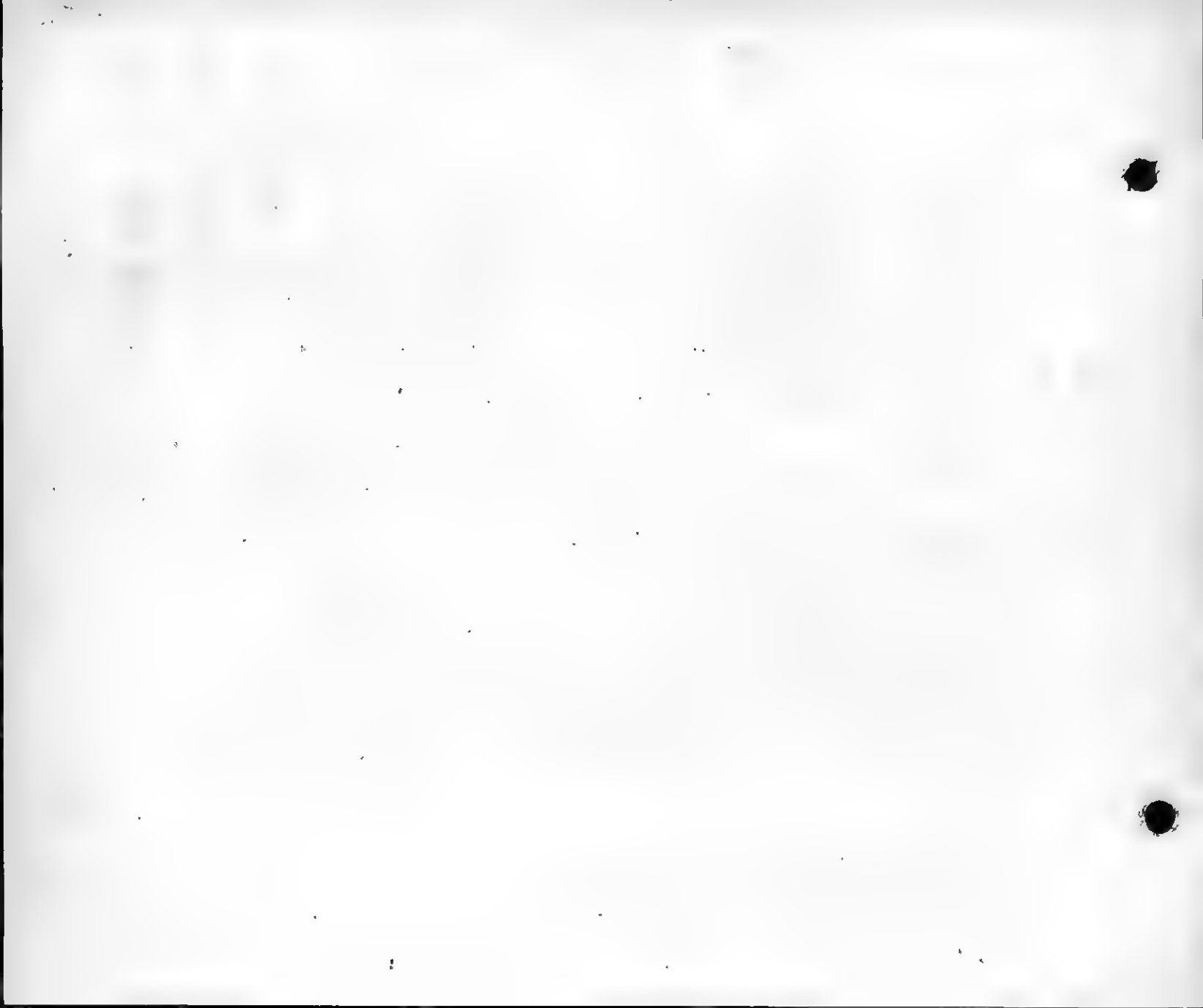
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>42 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>1294 W. Main Street.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>F.</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1892</u>	
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery</u>		11. BIRTHPLACE (State or foreign country) <u>Marysville, Pa.</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Washington Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Glessner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No.</u>		INFORMANT <u>Mr. Guy Rhodes, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 2, 1959</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Coronary Occlusion</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 2</u> , 1959, to <u>Nov 7</u> , 1959, that I last saw the deceased alive on <u>Nov 7</u> , 1959, and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>Nov. 7-59</u> ACTUAL SIGNATURE <u>Thelma H. Speckley</u> M.D. <u>Elkton, Md.</u> PHYSICIAN'S NAME (Type) <u>Thelma H. Speckley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Charles Town</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Town Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>		ADDRESS <u>Don't know</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12473

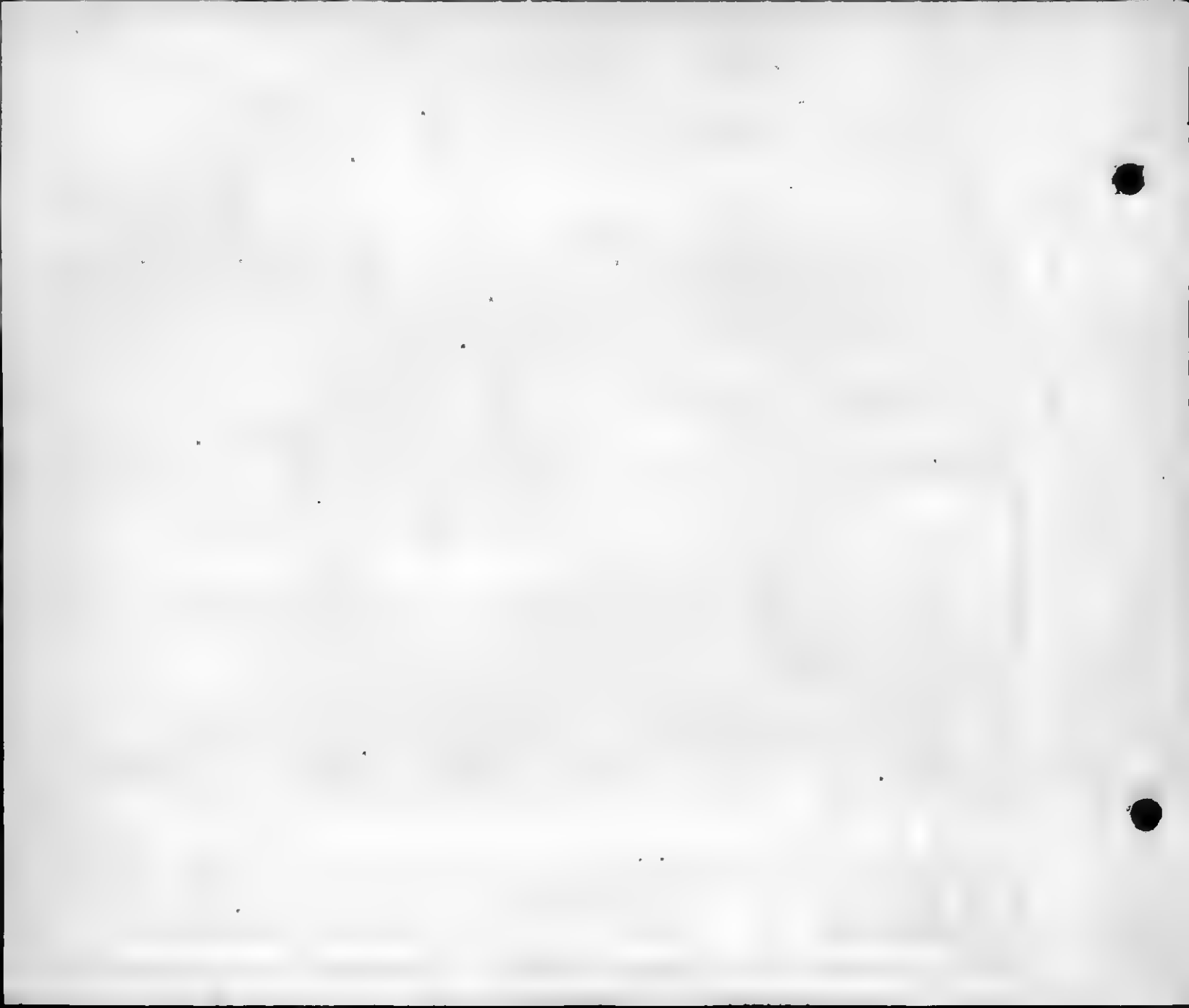
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Almedia Middle H. Last Smith		4. DATE OF DEATH Month Nov. Day 15th. Year 19 59	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20th 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Holden		14. MOTHER'S MAIDEN NAME Adranna Bennet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Holden Moore		Address Aberdeen Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Nov , 19 59 , to Nov. 15th , 19 59 , that I last saw the deceased alive on Nov. 15th , 19 59 , and that death occurred at 315 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wallace Owenshain M.D. Cecilton Md. 10 Nov 59			
ACTUAL SIGNATURE Wallace Owenshain			
PHYSICIAN'S NAME (Type) Wallace Owenshain M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/18/59	22c. NAME OF CEMETERY OR CREMATORY Warwick Cemetery	22d. LOCATION (City, town, or county) (State) Warwick Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lishman		24a. REC'D BY REGISTRAR DATE NOV 19 59	
24b. REGISTRAR'S SIGNATURE Charles J. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12490

CERTIFICATE OF DEATH

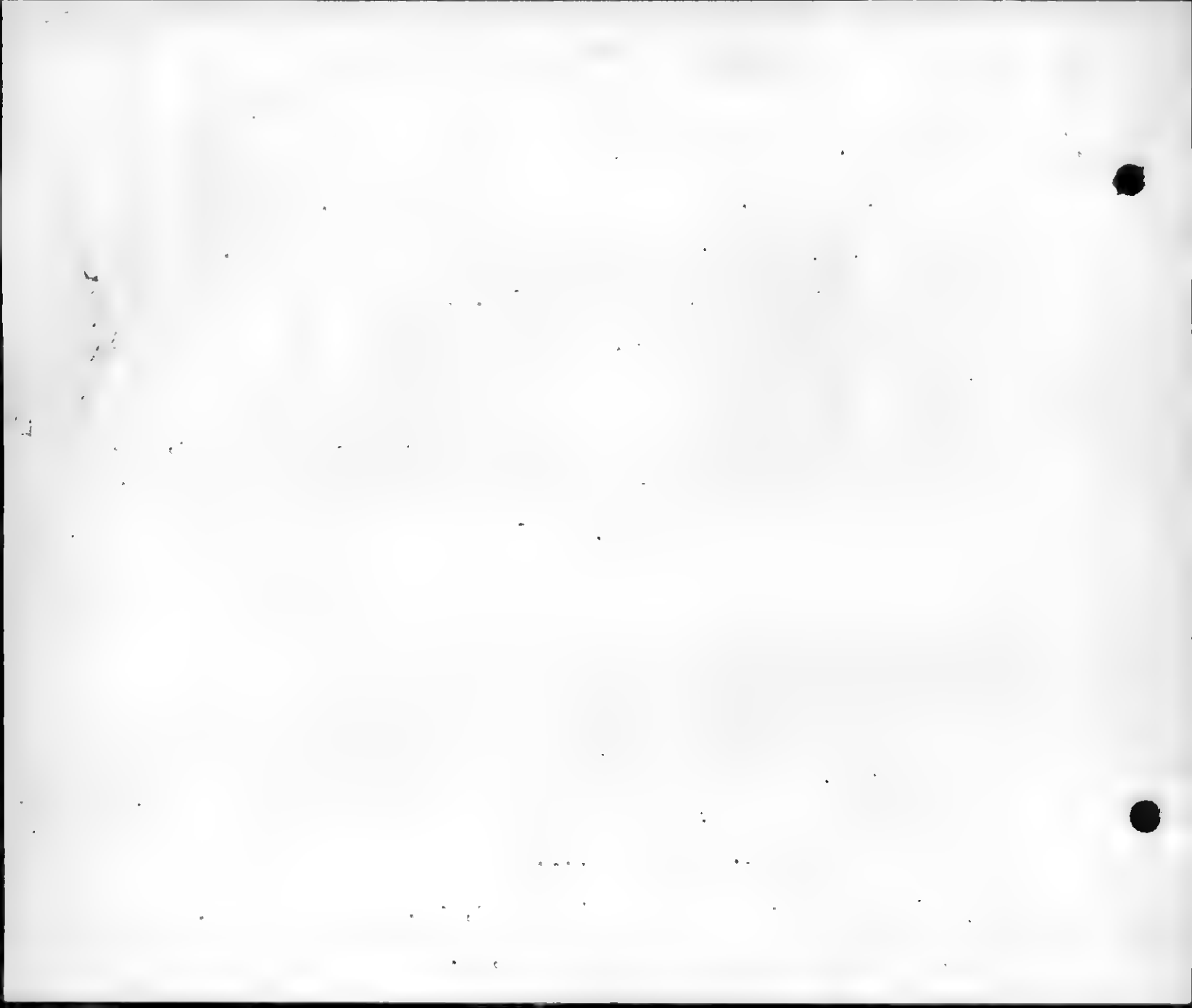
Reg. Dist. No.

12477

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
c. LENGTH OF STAY IN life Life		d. STREET ADDRESS Aikin Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Lackland Last Taylor		4. DATE OF DEATH Month NOV. Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1874
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR: Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telegraph operator		10b. KIND OF BUSINESS OR INDUSTRY B & O, R R	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Taylor		14. MOTHER'S MAIDEN NAME Eleanora Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Morton Taylor, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis - 422.1 DUE TO (b) Arterio-Sclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 7-4-10		INTERVAL BETWEEN ONSET AND DEATH 2-1-13	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April-17, 1959 to Nov. 25, 1959 , that I last saw the deceased alive on Nov. 25, 1959 , and that death occurred at 6:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence L. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 11-27-1959	
PHYSICIAN'S NAME (Type) Clarence L. Benson, M.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 11-29-1959	22c. NAME OF CEMETERY OR CREMATORY West Nottingham, Cem.	22d. LOCATION (City, town, or county) (State) Colora, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Leola Patterson ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE NOV 30 59	
		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12478

Reg. Dist. No.

12474

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Del. b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN life Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 228 W Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry First D. Middle Thompson Last				4. DATE OF DEATH Month 11 Day 3 Year 59			
5. SEX M	6. COLOR OR RACE W.	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-01		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Thompson				14. MOTHER'S MAIDEN NAME Agnus Grant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 222-07-3065		17. INFORMANT Mrs. Harry Thompson, 228 W. Main St. Middletown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Bodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Bodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/59		22c. NAME OF CEMETERY OR CREMATORY Old Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Middletown Del.	
23. FUNERAL DIRECTOR'S SIGNATURE G. J. Daniels				24a. REC'D BY REGISTRAR NOV 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12491

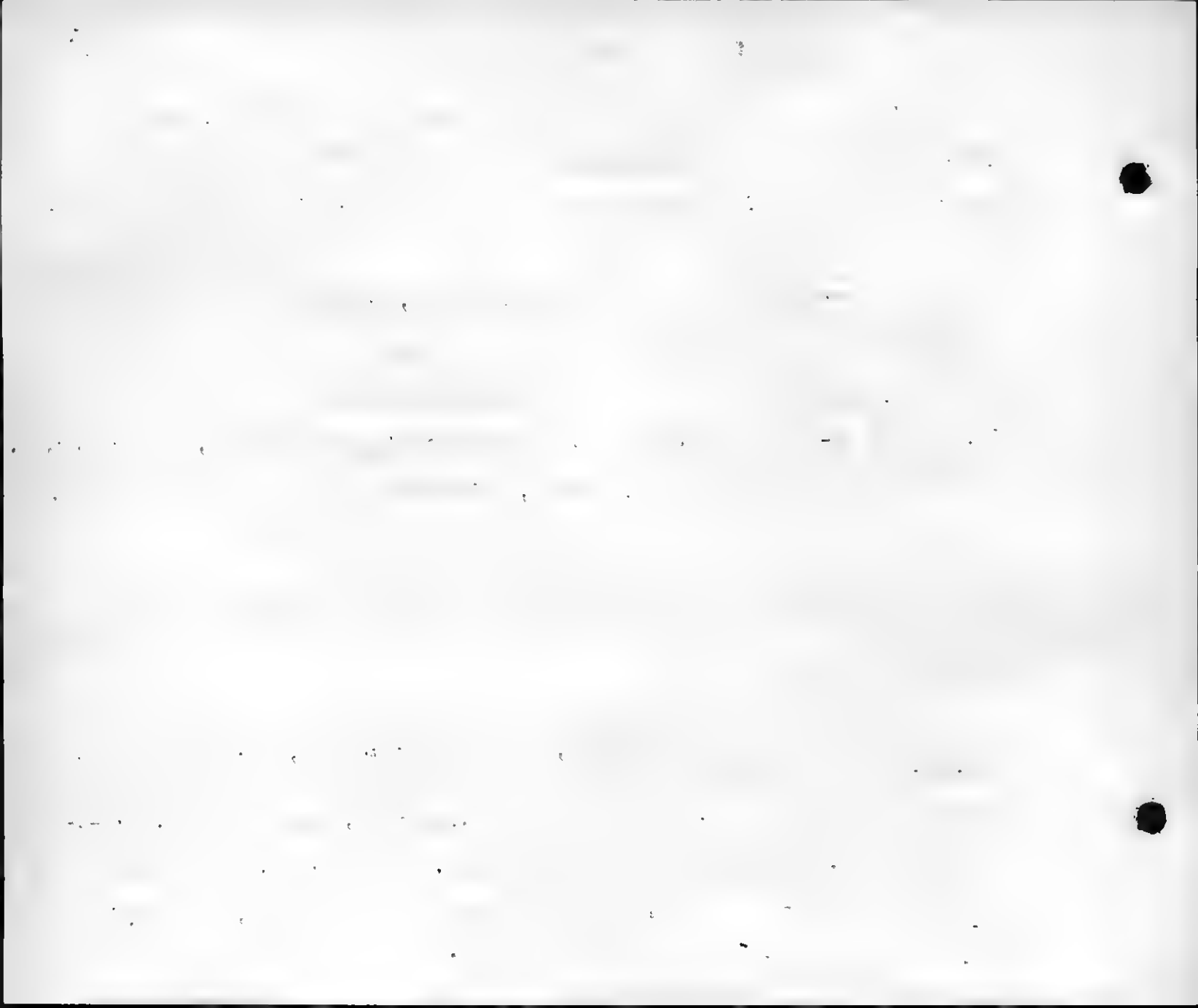
CERTIFICATE OF DEATH

Reg. Dist. No. 96

12479

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN 1b 3yrs5mos25days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 843 Carroll Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last WALKER		4. DATE OF DEATH Month November Day 4 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1894	9. AGE (In years last birthday) yrs 64	IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES WALKER		14. MOTHER'S MAIDEN NAME ALICE TERRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO Unknown		INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, bilateral 477X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 477X DUE TO (c) 477X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 477X					INTERVAL BETWEEN ONSET AND DEATH Approx. 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) VA		20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from May 10, 1956 to November 4, 1959 and that death occurred at 10:30AM from the causes and on the date stated above.					
ACTUAL SIGNATURE A. Bernardo		M.D. V.A. Hospital, Perry Point, Md. 11-5-59			
PHYSICIAN'S NAME (Type) A. BERNARDO		Asst. Chief, Surgical Service			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-9-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore,		22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE PHILLIP H. HARRIS		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR NOV 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris					

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

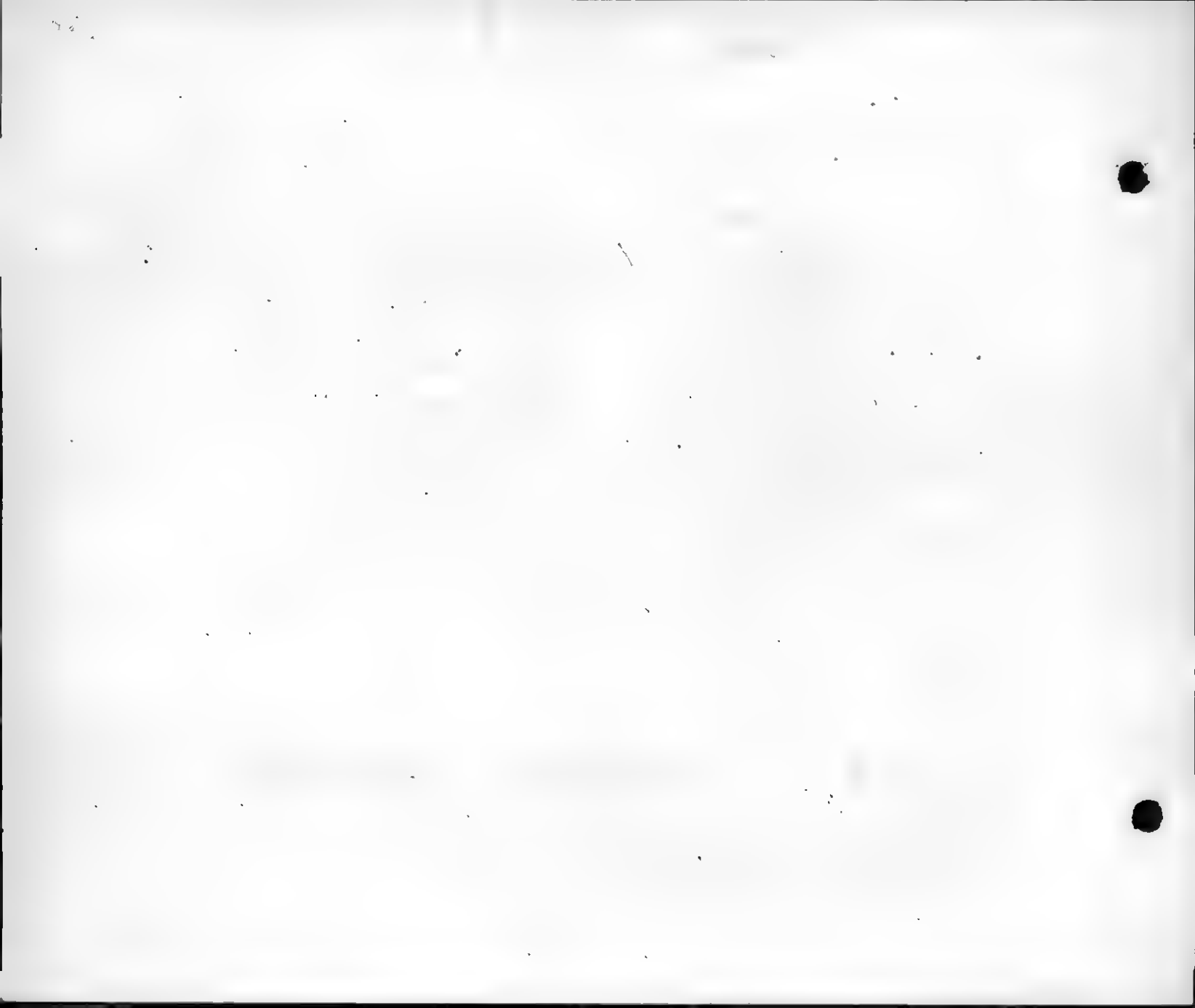
12492

CERTIFICATE OF DEATH

Reg. Dist. No.

12480

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>B</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1880</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>	11. BIRTHPLACE (State or foreign country) <u>Chesapeake City, Md</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George R Watson</u>		14. MOTHER'S M maiden name <u>Henrietta Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>169-20-1607</u>	
17. INFORMANT <u>LAURA L. WATSON</u> Address <u>CHES. CITY, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>156.1 Carcinoma of Liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleurothrombosis & pulmonary embolism.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>Nov 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> DATE SIGNED <u>11 Nov 59</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 12, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NR. CHESAPEAKE CITY, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>ELATTIN, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12481

12493

CERTIFICATE OF DEATH

Reg. Dist. No 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ELWOOD Last WESSEL		4. DATE OF DEATH Month November Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-03
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR: Months 55 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Wessel		14. MOTHER'S MAIDEN NAME Lena Story	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-14-3917	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neoplasm, left lobe of brain, (Temporal) DUE TO (b) Type undetermined. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 193.0		INTERVAL BETWEEN ONSET AND DEATH 4 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 17, 1959 , to November 24, 1959 and that death occurred at 8:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. H. Twining		DATE SIGNED 11-25-59	
PHYSICIAN'S NAME (Type) R. H. TWINING		M.D. V.A. Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 27	
22c. NAME OF CEMETERY OR CREMATORY Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane		ADDRESS Edgar Lane Funeral Home, Church Hill, Md.	
24a. REC'D BY REGISTRAR NOV 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knaus	

1994.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2020

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12494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Westmoreland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Youngwood 75 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital, Perry Point, Md.		d. STREET ADDRESS Box 69	
3. NAME OF DECEASED (Type or print) First JOSEPH W. Middle WOTTCZAK Last		4. DATE OF DEATH Month November Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1892
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wottczak		14. MOTHER'S MAIDEN NAME Unknown Nellie Micholobie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH - Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that deceased deceased on on at at the the place place and that death occurred at and that death occurred at 5:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH., Perry Point, Maryland DATE SIGNED 11-18-59 ACTUAL SIGNATURE J. L. Garney M.D. PHYSICIAN'S NAME (Type) J. L. GARNEY, M.D. CLINICAL PATHOLOGIST. 22a. BURIAL, CREMATION, REMOVAL removal 22b. DATE THEREOF 11-19-59 22c. NAME OF CEMETERY OR CREMATORY Youngwood Cemetery 22d. LOCATION (City, town, or county) (State) Youngwood, Pa. 23. FUNERAL DIRECTOR'S SIGNATURE Hayre DeGrade ADDRESS Hayre DeGrade 24a. REC'D BY REGISTRAR Nov 27 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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